Rosary Academy

2026 - 2027 Student Health History

Part 1 General Student Information:

Student's Name: Last	First	Grade:	Birth Date:	Sex: ☐ M ☐ F	Grad Year:
Home Phone: ( )	Student's Cell: ( )	Primary E-Mail:			
Home Street Address:		City:		Zip:	
Mother/Guardian Name and Phone Number: **H:** ( ) **W:** **C:** ( )		Father/Guardian Name and Phone Number: **H:** ( ) **W:** **C:** ( )			
Physician Name:		Phone: ( )			

Part 2 Health History (to be completed by parent or guardian) Please check the "yes" or "no" box below that applies to your student. If there are any changes to your student's health condition during the school year, please inform the school nurse. The Health Room may provide this information on a "need to know" basis with school personnel to ensure your student's health and safety while on campus or during school activities.

NO	YES	HEALTH INFORMATION
☐	☐	**Has your student had a complete physical exam in the past year (excluding sports physical)?**
☐	☐	**Activity Restrictions *Adaptive PE requires MD letter**
☐	☐	**ADD/ADHD (diagnosed by MD)**
☐	☐	**Allergy (life threatening) that requires use of an EpiPen (list allergy)_____**
☐	☐	**Will your student carry or store an EpiPen at school?**
☐	☐	**Allergy that requires use of Benadryl (specify allergy)_____**
☐	☐	**Allergy to Medication (list med)_____**
☐	☐	**Anxiety Disorder (diagnosed by MD)**
☐	☐	**Asthma (diagnosed by MD) ☐ Mild ☐ Moderate ☐ Severe**
☐	☐	**Will your student carry or store an Asthma Inhaler at school?**
☐	☐	**Autism/Asperger's**
☐	☐	**Back or Neck Problems/Scoliosis/Arthritis**
☐	☐	**Bleeding Tendencies/frequent bloody nose**
☐	☐	**Cancer**
☐	☐	**Concussion Date of last Concussion:_____**
☐	☐	**Crohn's Disease / Ulcerative Colitis**
☐	☐	**Cystic Fibrosis**
☐	☐	**Depression (diagnosed by MD)**
☐	☐	**Diabetes**
☐	☐	**Digestive Problems**
☐	☐	**Hay Fever/Seasonal Allergies ☐ Mild ☐ Moderate ☐ Severe**
☐	☐	**Eating Disorder (please specify)**
☐	☐	**Epilepsy/Seizures**
☐	☐	**Fainting history**
☐	☐	**Hearing or Ear Issues**
☐	☐	**Heart Condition**
☐	☐	**Hospitalization/Surgery (recent)**
☐	☐	**Immunocompromised (weakened or absent immune system)**
☐	☐	**Injury of a muscle/bone/joint/tendon (recent)**
☐	☐	**Kidney or Bladder Problems**
☐	☐	**Learning Differences**
☐	☐	**Migraine headaches (diagnosed by MD) Treatment:**
☐	☐	**Painful menstrual periods (severe pain that disrupts normal daily activity)**
☐	☐	**Physical Impairment**
☐	☐	**Sinus Problems**
☐	☐	**Skin Problems/Eczema**
☐	☐	**Vision Problems/Correction**
☐	☐	**Other (specify/explain any of the above conditions)**

Part 3 Medications Medication cannot be taken at school without a **Medication Administration Consent Form** signed by a parent (for over-the-counter meds) or a parent and physician (for prescription meds). All meds must be in their original, sealed container and delivered by an adult to the Health Room and stored there. Students are not allowed to carry medications or keep meds in their bags, lockers or cars. EpiPens and Inhalers may be carried by the student with a Medication Form signed by their physician. The Health Room provides the medication listed below with parental consent:

Consent for student medication	**Sudafed PE** **Phenylephrine HCL 10mg** decongestant ☐ **Yes** ☐ **No**	**Advil** **Ibuprofen** pain reliever ☐ **Yes** ☐ **No**	**Tylenol** **Acetaminophen** pain reliever ☐ **Yes** ☐ **No**	**Claritin Benadryl** **Loratadine** antihistamine ☐ **Yes** ☐ **No**	**Midol (for girls)** **Tylenol Menstrual Relief** pain/diuretic/antihistamine ☐ **Yes** ☐ **No**	**Tums** **CalciumCarbonate** antacid ☐ **Yes** ☐ **No**

Will your student need other medication(s) at school: ☐ Yes ☐ No List routine meds taken at home and/or school:

This health history is complete and accurate to the best of my knowledge. Parent/Guardian Signature_____Date:_____